DOCUMENT RESUME

ED 330 967 CG 023 310

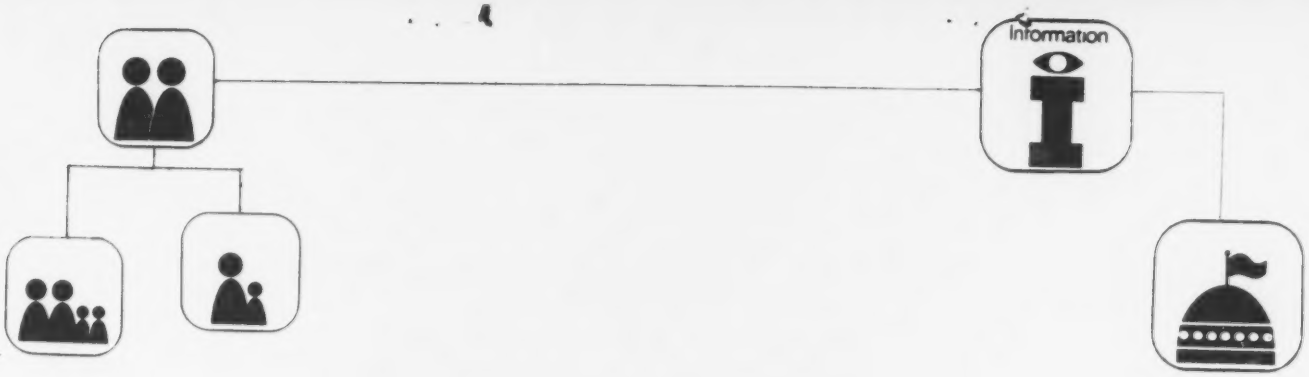
AUTHOR Ooms, Theodora; Golonka, Susan
TITLE Evolving State Policies on Teen Pregnancy and Parenthood: What More Can the Feds Do To Help?
INSTITUTION American Association for Marriage and Family Therapy, Washington, DC. Research and Education Foundation.
SPONS AGENCY Mott (C.S.) Foundation, Flint, Mich.
PUB DATE 90
NOTE 46p.
AVAILABLE FROM Family Impact Seminar, 1100 17th St. NW, 10th Floor, Washington, DC 20036 ($10.00).
PUB TYPE Collected Works - Conference Proceedings (021)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Adolescents; *Early Parenthood; *Federal Programs; Federal State Relationship; *Pregnancy; State Programs; Unwed Mothers

ABSTRACT

This report includes the meeting highlights from a policy seminar which looked at successful models of state action taken by Illinois, Maryland, and North Carolina to reduce the incidence of adolescent pregnancy. Shirley Randolph, Associate Director of the Illinois Department of Public Health, described the Illinois initiative called Parents Too Soon, which serves as a coordinating agency for 125 community-based organizations. Bronwyn Mayden, Executive Director of the Governor's Council on Adolescent Pregnancy in Maryland, provided the history and background of the council, which directs Maryland's joint executive/legislative initiative to establish a Maryland Task Force on Adolescent Pregnancy. A successful public/private fundraising campaign to produce television "spot" commercials directed toward adolescents initiated by the council, the Campaign for Our Children, is described. Barbara Ziegler, Executive Director of the Mecklenburg Council on Adolescent Pregnancy and founding member of the North Carolina Coalition on Adolescent Pregnancy describes the state's initiative which, unlike Illinois and Maryland, is largely centered in the private sector. Ongoing efforts discussed include training local representatives, publishing a quarterly newsletter, and producing brochures and other related materials. Each panelist responded to a question about the role of the federal government in the area of adolescent pregnancy. The report is followed by a background briefing report which covers the following topics: (1) goals of teenage pregnancy policy; (2) inventories of federal programs related to teenage pregnancy and early childbearing; (3) teenage pregnancy legislation in the 101st Congress; (4) trends in state policy; (5) three exemplary state initiatives; (6) what the federal government can do to help; and (7) a summary listing of federal programs. (LLL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****



ED330967

Evolving State Policies on Teen Pregnancy and Parenthood: What More Can the Feds Do To Help?

July 30, 1990, 210 Cannon House Office Building

Panelists: **Shirley Randolph,** Associate Director, Illinois Department of Public Health
Bronwyn Mayden, Executive Director, Governor's Council on Adolescent Pregnancy, Maryland
Barbara Ziegler, Founding Board Member, North Carolina Coalition on Adolescent Pregnancy

Moderator: **Theodora Ooms,** Director, Family Impact Seminar

BEST COPY AVAILABLE

CG023310

Highlights.....pages i to vii
Background Briefing Report.....pages 1 to 32

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Todd Owen

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Evolving State Policies on Teen Pregnancy and Parenthood: What More Can the Feds Do To Help?

Background Briefing Report
and
Meeting Highlights

by

Theodora Ooms and Susan Golonka

This policy seminar is one in a series of monthly seminars for policy staff titled, *Family Centered Social Policy: The Emerging Agenda*, conducted by the **Family Impact Seminar**, American Association for Marriage and Family Therapy, Research and Education Foundation, 1100 Seventeenth Street, N.W., The Tenth Floor, Washington, D.C. 20036, 202/467-5114

This seminar was co-sponsored by the Consortium of Family Organizations (COFO) and funded by the Charles Stewart Mott Foundation.

COFO Members:
American Association for Marriage and Family Therapy (AAMFT)
American Home Economics Association (AHEA)
Family Resource Coalition (FRC)
Family Service America (FSA)
National Council on Family Relations (NCFR)

Copyright © 1990
The Family Impact Seminar (FIS), The AAMFT Research and Education Foundation, Washington, D.C.
All Rights Reserved.

This Background Briefing Report may be photocopied for education, teaching, and dissemination purposes provided that the proper attribution is prominently displayed on the copies. If more than 50 copies are made, FIS must be notified in writing, prior to duplication, of the number of copies to be made and the purpose of the duplication.

TABLE OF CONTENTS

	Page
Highlights	i - vii
Introduction	1
Goals of Teen Pregnancy Policy	2
Inventories of Federal Programs Related to Teen Pregnancy and Early Childbearing	6
Teenage Pregnancy Legislation in the 101st Congress	8
Trends in State Policy	10
Three Exemplary State Initiatives	12
What More Can the Feds Do to Help?	16
Summary Listing of Federal Programs that Affect Teen Pregnancy	21
Selected References	28
Table 11: Summary of Major State Responses to Adolescent Pregnancy and Parenting	31-32

Evolving State Policies Towards Teen Pregnancy and Parenting:

What More Can the Feds do to Help?

Highlights of the seminar meeting held on July 20, 1990 in the Mansfield Room, (S.207), U.S. Capitol. (A supplement to the background briefing report.)

Theodora Ooms introduced the seminar by saying that a majority of states have taken some formal actions to develop a statewide response to the problems of teenage pregnancy and parenting. These statewide initiatives have several features in common. States have focused broadly both on prevention of the initial pregnancy and on improving outcomes for mother and child. Most states have mobilized a wide range of resources including those in the private sector. Each state has had to deal with the sensitive politics of teenage pregnancy, since it is a topic in which government intervention has often proved to be controversial. Yet states have used very different organizational models to achieve these goals and the initiative and leadership have emerged from different sectors. The panelists at this seminar were asked to present the successful, yet very different models of state action taken by Illinois, Maryland and North Carolina.

The first panelist **Shirley Randolph,** Associate Director of the Illinois Department of Public Health, described Illinois' initiative called **Parents Too Soon** which is centered in the executive branch.

Parents Too Soon was the first coordinated statewide assault on adolescent pregnancy in the nation. The effort began in 1980 when the Illinois Conference of Women Legislators held hearings around the state on the problem. As a result of the attention drawn to the issue, the Governor directed the state Department of Public Health to develop a plan to coordinate all agencies involved in teen pregnancy programs and map out a strategic plan for action.

The program, begun in 1983, has the following three major goals: To reduce the incidence of teen pregnancy, reduce the health risks associated with early childbearing, and help teen parents adapt to the responsibilities of parenthood. The state is deeply committed to the program: the FY '91 budget for Parents Too Soon (PTS) is $19.8 million, the largest amount of funding committed by any state to this project. In FY '89, 74,000 teens received direct services and 135,000 received sexuality related information.

Through interagency collaboration the state works to provide critical medical and social services, discourage teen pregnancy, encourage teens to stay in school, ensure the physical and emotional health of young parents and their children, improve job opportunities, mitigate welfare dependency, and teach adolescents to be good parents.

Parents Too Soon serves as the coordinating state agency and receives funding from three state departments---Public Health, Public Aid, and Children and Family Services. In addition, seven other agencies are involved and each has appointed a staff member to the PTS task force which meets quarterly to facilitate coordination. Coordination is considered critical to avoid the fragmentation, gaps and overlap that then existed among the many different agencies dealing with facets of the problem and the different federal funding streams. (See organization chart on page vii and listing of federal programs on page 21-27.)

In Illinois, local community-based service groups are the locus of the effort. While PTS serves as the funding source, sets policy direction, and guides program development, local community agencies design and operate programs to suit their local needs. Presently, 125 community-based

organizations are involved in providing services funded through PTS, including local Planned Parenthood chapters, Catholic Charities, public hospitals, local health departments, public schools, and others. These agencies provide services under a contractual agreement with PTS. Currently, 75% of Illinois' 102 counties and all areas of high population density are served.

As at the state level, cooperation among local agencies is important. In order to receive funding, local agencies must provide letters of agreement with other appropriate local agencies. These agencies must agree to formally refer participants among themselves and are encouraged to plan in conjunction with one another.

Some community agencies focus on prevention, others direct service, some do both. Among the services provided are:

---family planning (including abstinence)
---pre-natal care
---nutrition counseling
---parenting training
---day care
---vocational training
---assistance in finishing high school
---drug and alcohol counseling
---home visitors
---transportation and other supports.

Shirley Randolph stated the philosophy of the program as: "Teens are served best when services are coordinated and targeted to their needs at the local level." Opposition from religious organizations to the five school-based clinics funded by the state was mitigated because it was the local communities, not the state, which decided whether the clinics would prescribe and/or dispense contraceptives.

Randolph also described their public/private partnership program called the **Ounce of Prevention Fund**, which was started in 1982 by the Pittway Charitable Foundation in cooperation with the Department of Public Health. The Fund helps to fund the school-based clinics, the PTS hotline, and public awareness programs like those encouraging parents and teenagers to talk together about sexuality.

Randolph concluded that Parents Too Soon represents an unprecedented collaboration and extraordinary working relationship among three major state agencies, the Governor's Office, and local organizations. She said the programs have been successful in meeting the overall goals of reducing low birth weight, reducing primary and secondary births to teens, reducing infant mortality, and shortening the period of welfare dependency. In 1987, PTS received the Innovation in State and Local Government Award from the JFK School of Public Policy, Harvard and the Ford Foundation.

Looking ahead, Randolph believes that there is a need for more programs that develop basic skills and that federal programs such as JOBS can play a role here. She also commented that more funding should be available for evaluation of programs so we can better understand what works and what doesn't.

The second panelist was **Bronwyn Mayden,** Executive Director of the Governor's Council on Adolescent Pregnancy in Maryland. She began by providing the history and background of the Council which directs the joint executive/legislative initiative.

In 1985, in light of discouraging statistics on adolescent pregnancy and after the persistent urging from Ruth Masssinga, the Secretary for Human Resources, then-Governor Harry Hughes agreed to establish a Maryland Task Force on Adolescent Pregnancy. The Task Force included representatives from the legislature and executive branch, business leaders, and private citizens. In an effort to confront the difficult political issues early and head-on, the Governor appointed both pro-life and pro-choice legislators to serve on the Task Force.

After much discussion, the Task Force issued a consensus report entitled *Call to Action* which concluded that Maryland could rise to the challenge of turning a tragic situation into an opportunity for constructive change. However, any effort to alleviate the problem would require a sustained, coordinated commitment to an incremental, long-term program. Based upon the recommendations of the Task Force, the state legislature passed a bill that established the Governor's Council on Adolescent Pregnancy to which she, Mayden, was appointed the Director. The Council was charged with the following general tasks:

---coordinate planning and program development;
---follow-up on the Task Force recommendations;
---conduct data collection and analysis;
---promote interagency public and private coordination;
---monitor statewide projects;
---provide community information and coordination;
---grants management; and,
---technical assistance to local governments.

Mayden believes Maryland is fortunate because the legislation mandates that the Council receive funding to support a staff of five individuals, thus providing the Council with a reliable source of stable funding. The legislature has also provided money for a media campaign targeting adolescents aged 9 to 14, that promotes postponement of sexual activity and funding for prenatal care for pregnant teenagers. Mayden described the Council's primary role as coordination among department and agency directors, legislators, and business people.

The Council believes that many different strategies are needed. While the Council is involved in media campaigns that promote abstinence or delayed sexual activity, more than half of the teens are sexually active and thus their efforts need to reflect this reality. The Council was successful in getting the legislature to increase funding for family planning services and for case management services for at-risk, pregnant and parenting teens. Mayden also emphasized the value of Maryland's community incentive grants program. She agreed with Shirley Randolph's point that efforts will only be successful if local communities take teen pregnancy on as their problem. The Council's grants provide the "hook" to get local groups involved.

A particularly successful program initiated by the Council has been the **Campaign for Our Children** a public/private partnership which has resulted in over $3 million in contributions from the private sector. She attributed the success of this fundraising campaign to the involvement of a prominent business leader who took the lead role in soliciting funds from the private sector. These contributions have been used to fund a sophisticated media campaign and an after-school program to engage young people in a variety of activities that help build self-esteem. (For more information see page 14-15.)

Mayden concluded her presentation by showing several TV "spot" commercials recently aired on commercial stations in Maryland, oriented to teens, which focus on male responsibility, postponing sexual activity, peer pressure, and the consequences of early child-bearing. These highly effective and professional announcements were paid for by the Campaign for our Children and the state of Maryland.

The final speaker, **Barbara Ziegler,** is the Executive Director of the Mecklenburg Council on Adolescent Pregnancy and a founding member of the North Carolina Coalition on Adolescent Pregnancy. Ziegler described the origins and present activities of the state's initiative which, unlike Illinois and Maryland, is largely centered in the private sector with little involvement from the administration. The Legislature has been incredibly supportive.

"North Carolina," Ziegler said, "is a state with many contradictions. It has a Republican governor but a Democratic legislature. It has many progressive policies: the state guarantees a minor's right to health care, it is the home of the first publicly-funded family planning program in the nation, and has six school-based clinics. At the same time, however, it has the highest infant mortality rate in the nation, the lowest SAT scores, and 28,000 teen pregnancies a year, 75% of these are out-of-wedlock."

She reported that publicizing facts such as these helped to bring the problems of adolescents to the attention of local communities, particularly the local business people who are concerned about an adequate workforce. After several years of discussion about the problem of teen pregnancy, the United Way in 1985 decided to fund a staff person to create an independent, statewide coalition to coordinate all teen pregnancy programs across the state.

Today, the **North Carolina Coalition,** with funding from the United Way of North Carolina, foundation grants, the Legislature, and individual contributions has a budget of $260,000, four staff people, a liaison in the state capital, and a 30 member Board of Directors. Despite its modest size, the Coalition, which regards itself as a public/private partnership, has been responsible for developing 51 local councils. Ongoing efforts include training local representatives, publishing a quarterly newsletter, and producing brochures and materials for local councils and others to use. They have launched a campaign, **"Let's Talk"** which encourages parents to educate their children about sex. The Coalition was also successful in getting the state legislature to create a five-year adolescent pregnancy prevention program which funds projects across the state.

As in Illinois and Maryland, the heart of the effort is at the community level. The Coalition encourages local agencies to work together on all facets of adolescent behavior such as drug and alcohol abuse, school retention, and delinquency. Ziegler commented that taking a broader approach has been successful in Mecklenburg County and has brought even the most conservative organizations into the local effort to prevent teen pregnancy.

Ziegler considers the Coalition's outlook to be bright and they are undertaking new projects such as statewide conferences for youth, reaching out to clergy and media, focusing on secondary prevention through special school programs, creating an 800 number, and establishing an institute at a North Carolina university to train teachers for family life education.

The Federal Role

Following their individual state focused presentations (for additional details see pages 12-16), Ooms asked each panelist to comment on whether the federal government was doing enough in the area of adolescent pregnancy and if they had any ideas of what else the federal government could be doing.

Shirley Randolph said she believed that because the issue is so controversial, the federal government has largely avoided exercising the national leadership that is needed. Additionally, she felt the federal government should do the following:

---Provide technical assistance to state and local programs;

---Assist in transfer of information on successful approaches, perhaps through developing a library or clearinghouse;
---Set aside funds for the purpose of evaluating programs and especially those attempting to reach high-risk teens; and,
---Improve coordination among federal agencies.

Bronwyn Mayden felt that the federal government needs to change its attitude and outlook regarding solutions to the problem. She felt the federal government tends to view teens as a monolithic group with abstinence the only proper approach to pregnancy prevention. They need to adopt an attitude which embraces multiple approaches to meet the situation of different sub-groups of teens. Additionally she identified the following needs:

---Increase funding for preventative services;
---Place more emphasis on male responsibility and programs geared toward males such as contraceptive services, education, jobs, and parenting courses; and,
---Improve coordination among federal programs.

Barbara Ziegler provided the following recommendations for increased federal involvement:

---Establishment of universal primary prevention programs;
---Increased funding for evaluating projects;
---Increased funding for Title X, family planning services;
---Passage of the Adolescent Family Life bill; and,
---Increased jobs and training for adolescent parents.

Points raised during the discussion:

- One participant asked whether there was any interaction or coordination in the states between the teen pregnancy programs and the JOBS program (established by the Family Support Act)? Randolph felt there aren't enough jobs available in Illinois for JOBS to be successful and emphasized that it's difficult to find adequate child care for the young children while the teens are in school or training. Mayden said that while teens are a high priority in JOBS, infant care is very hard to find in Maryland and very costly. Ziegler also cited child care as a problem in North Carolina.

- A congressional staffer wondered if any studies had demonstrated a correlation between teen pregnancy, school dropouts, and drug abuse. A member of the audience from the National Institute for Child Health and Development reported that a study funded by NICHD will soon be available on this question (see ** below). Additionally, the National Academy of Sciences is conducting a study that will examine the interrelationship among these problems. Ooms commented that, at least until recently surveys and studies have tended to focus on a single specific problem in isolation, which is why there is so little research illuminating the connections between teenagers' problems that we all know exist.

- A member of the audience was interested in learning more about the teen pregnancy hotlines that several states have. Who calls and what sort of information do they receive? Mayden said that the hotline in Maryland goes into the Health and Welfare Council office at the Council and that the caller, usually teens or parents, will speak to individuals who are trained by the Governor's Council to give information and counseling, generally about human sexuality. Similarly, in Illinois trained counselors answer the phones. Randolph noted that after a teen pregnancy spot airs on TV that there is always a large influx of calls. She said little is known about how the information is used because the conversations are confidential and there is no follow up. Illinois

updates a computerized resource directory continually so the information will always be up to date. Barbara Ziegler described a successful prime-time, one-hour telethon on family sexuality hosted by a local affiliate in North Carolina. They received over 800 calls in one hour.

- A comment by an official from HHS sparked a lively discussion on male responsibility, marriage, and efforts to encourage teen fathers to become involved with their children. In Maryland, there are 13 family support drop-in centers providing direct services which have special group sessions for males. In addition, Mayden commented that a Young Father's Program has been very successful in Harford County where a judge has ordered young males who are unable to pay child support to return to school or get job training. In Illinois, where 79% of births are to unwed mothers, Randolph said that focus groups have been started where the young fathers talk with counselors about what it means to be a parent.

  Few participants viewed marriage as a solution, particularly since many of the young men are unemployed and may have several children by different women. A foundation officer noted that these early marriages usually don't last. Ziegler emphasized that campaigns to reduce teen pregnancy must be culturally relevant in order to be successful. In some communities, postponing sexual activity or getting married is just not considered acceptable.

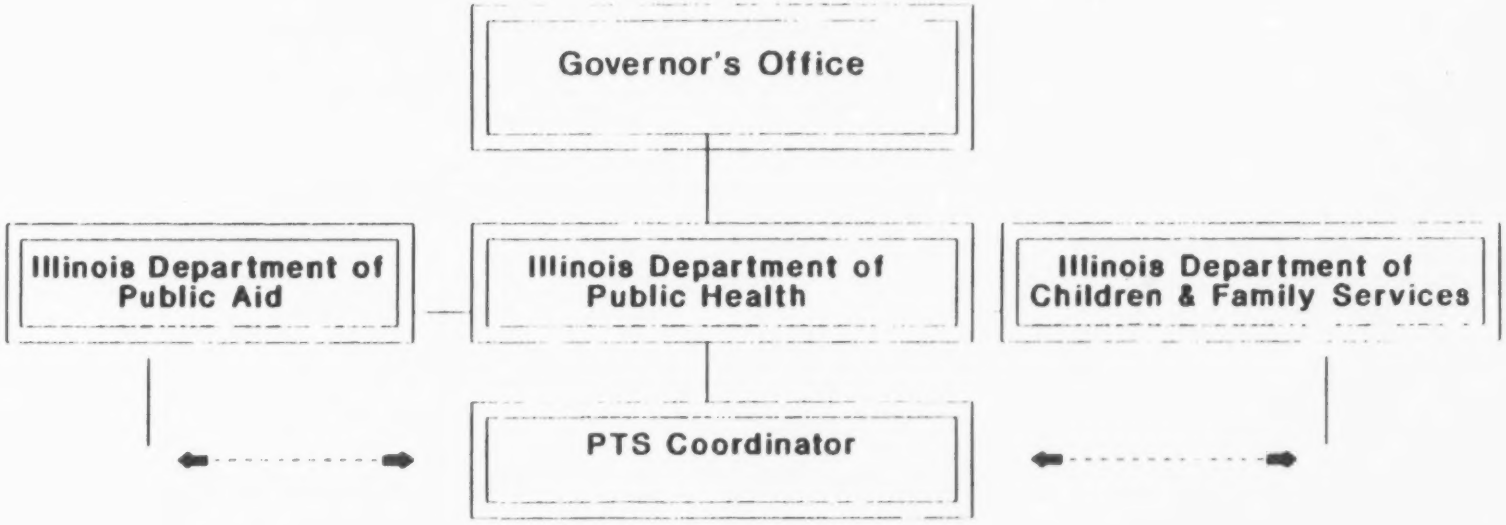
  A researcher at Mathematica Policy Research said that the teen parent demonstrations in Illinois and New Jersey have included a component for male partners. He noted that it is hard to get them involved. The "hook" is helping them get a job or job training. Also, they found that the young women are not interested in marriage to the baby's father.

  Ooms noted that nowadays we usually think of male responsibility as meaning not getting a girl pregnant or, if you are already a father, to become involved with and financially support your child. Getting married is not usually included in the definition of unwed fathers' responsible behavior. However, some people would frame the moral issue of male responsibility somewhat differently, as being the obligation not to impregnate a young woman until and unless you're ready to get married to her and support a family.

- One member of the audience questioned whether it's difficult to coordinate programs such as job training and remedial education with agencies that do not particularly view teen parents as their priority. Randolph said that in Illinois they have brought agencies like employment services and education on to their Interagency Task Force. Mayden also said they have involved these agencies on the council and, perhaps more importantly, they have used the political clout of the Governor to get the cooperation they need.

** See *Teen Pregnancy Handout,* September 1990, published by the Center for Population Research at the National Institute for Child Health and Development, DHHS (301-496-1174). This handout quotes research on the sequential timing of teen sexual activity and drug and alcohol use conducted by James Jaccard, professor at S.U.N.Y., Buffalo.

PARENTS TOO SOON PROGRAM
ORGANIZATIONAL CHART


Governor's Office
Illinois Department of Public Aid
Illinois Department of Public Health
Illinois Department of Children & Family Services
PTS Coordinator

- Fiscal Management
- Young Parents Program
- Project Advance
- Comprehensive School Based Clinics

- Lead Agency For Coordination
- Comprehensive Projects
- Comprehensive School Based Clinics
- Male Responsibility
- Prenatal
- Family Planning
- WIC
- Teen Leadership Conferences
- Community Awareness and Education
- Employment/Education Linkages
- AIDS Projects
- Hotline
- Special Projects

- Public Relations
- Ounce of Prevention Fund
- Positive Youth Development

BEST COPY AVAILABLE

EVOLVING STATE POLICIES ON TEEN PREGNANCY AND PARENTHOOD:

WHAT MORE CAN THE FEDS DO TO HELP?

Background Briefing Report

INTRODUCTION

Whose responsibility is it to assume the leadership and primary responsibility for public policy concerned with adolescent pregnancy and too-early childbearing? Health care professionals and advocates first alerted the public to the problems associated with adolescent pregnancy in the mid-seventies. Initially the federal government assumed the leadership on this issue and in 1978 established the first federal program solely and explicitly devoted to the problems of this population, a grants program administered by the Office of Adolescent Pregnancy Programs, DHEW.

By the mid-eighties however the policy initiative and leadership had largely passed to the states. Increasingly governor's offices, state legislators, and state private-sector organizations studied the dimensions of the problem in their state and initiated a wide range of activities to reduce the rates of teenage pregnancy and the negative consequences of too-early childbearing.

Several overarching themes have shaped the development of public policy at both state and federal level. They evolved in part in response to new findings from research and program experience, and in part from a vigorous public discussion about the values involved.

- Teen pregnancy is not simply a health issue: adolescent childbearing plays a large role in the present high levels of child poverty. Thus many health, education, and social programs need to be involved to prevent teenage pregnancy and meet the multiple and interrelated needs of pregnant teenagers, teen parents, and their babies.

- Teen pregnancy and childbearing is not only a private crisis for the individuals and families involved but also involves substantial public costs. Teenagers who give birth are at much higher risk of school drop-out and receiving AFDC and other public sources of financial support and assistance for many years. Their babies are more likely to be born prematurely, have low birth weight, or die in their first year than those of women in their twenties. In 1985, the total public outlays for three major programs---AFDC, food stamps, and Medicaid---provided to families begun by a teenage birth were nearly $17 billion (Burt & Levy, 1986).

- Certain subgroups of the population, especially low-income blacks and Hispanics, are at much higher risk of early childbearing than others. And for them the consequences are more serious and the causes are more deep-rooted and interrelated with other social and community problems. Thus, teen pregnancy related programs need to give priority to low-income, minority youth.

- Pregnancy prevention programs and services for pregnant women and mothers and their children are not effective for the adolescent population unless they are specifically redesigned and administered in ways that take into account adolescents' specific needs and stage of development, and respect their diverse cultural, religious, and socioeconomic backgrounds.

- Teenage sexual activity, pregnancy, and childbearing are highly sensitive issues arousing strong feelings and opinions about sexual morality and the role of government in family life. Hence, several of the policy options and strategies proposed or enacted have aroused serious controversy.

This report presents a review of the scope and current trends in federal and state policy towards teenage pregnancy. It then raises a number of questions about the federal role.

---What is the most appropriate and effective federal role in teen pregnancy prevention?

---How can the federal government strengthen state and community efforts to help teen parents?

---How do new federal initiatives in welfare reform, substance abuse, services to children with special health care needs, and AIDS prevention relate to existing programs and services targeted on teenagers and parents?

---Recent reports call for an increased federal role in coordination of all the various programs that could or do have an impact on the problems of teen pregnancy. Why is coordination needed at the federal level? What could it accomplish and how?

Note: The research on adolescent pregnancy and childbearing and evidence about policy and program effectiveness will not be reviewed in this briefing report. They were the subject of two seminars conducted last year (see briefing reports, Ooms and Herendeen, May 16 and October 13, 1989).

GOALS OF TEEN PREGNANCY POLICY

(Sources: Hayes, 1987; Henshaw, Kenney, *et al.*, 1989; Moore, 1981 and 1983; Moore and Burt, 1982; Ooms, 1981; Select Committee, 1990; Weatherley *et al.*, 1986)

Definitions: There is considerable ambiguity and confusion over some of the terms used in published reports of teen pregnancy data and research and in policy discussions. For example, the age period covered by the terms *"teenage"* and *"adolescent"* can vary beginning anywhere between ages 10-14 and extending through ages 18, 19, 20, or even 21.

A second ambiguity is in the use of the term *teen pregnancy prevention* in policy discussions. Sometimes it is used narrowly to mean primary prevention, that is of adolescents' first pregnancies. Sometimes, when access to abortion is included as a strategy, it includes prevention of teenage pregnancies and births. At other times it is used as a short hand term to mean primary and secondary prevention, namely the variety of strategies that aim to prevent teenagers' first and subsequent pregnancies and lessen the impact of all the negative consequences associated with too-early childbearing.

In spite of the controversies of particular strategies, there is general consensus on the major goals of public policy at federal, state, and local levels concerned with adolescent pregnancy and too-

early childbearing. The goals which obtain a clear consensus can be grouped into the following three general categories.

- To prevent first pregnancies among teenagers, especially among those of school age.
- To improve the health, development, and general well-being of the pregnant teen, teen mother, and her infant and to prevent subsequent births.
- To help teen parents become responsible, self-sufficient adults who can financially support their families and care adequately for their child(ren).

The National Research Council's report (Hayes, 1987) however collapsed these three into two categories, de-emphasizing teen parents financial responsibility and self-sufficiency and adding a separate third goal---"to provide alternatives to adolescent childbearing and parenting", meaning adoption counseling and abortion services. The fact that these components of teen pregnancy policy are much less frequently mentioned in policy discussions and reports is undoubtedly due to their political sensitivity.

This is a very broad policy agenda. Specific program strategies to accomplish these goals have evolved and expanded in scope over the last decade largely in response to the findings of a growing body of research investigating the causes and consequences of adolescent pregnancy. The experience of two decades of programs providing services to this population has also affected the scope and design of policy. In addition, policy intervention strategies broadened and shifted when, in the eighties, individuals with more conservative values began to have increased influence over the design and implementation of public policy.

Evolution of primary prevention strategies

In the seventies, teen pregnancy prevention strategy was confined to providing youth with sex education and teenage girls with access to contraceptives. New research however, emphasized that reproductive information and access to contraceptive services were necessary but not sufficient: many youngsters were not motivated to practice birth control. Studies found that those young people with strong self-esteem, good school adjustment and performance, and who had high expectations and ambitions for their own future were much less likely to become sexually active at an early age and to become teen parents.

Consequently the armamentarium of prevention programs broadened to include: (a) sex and family life education curricula that focus on value choices, decision-making skills, and teaching changing behaviors; (b) "life options" programs designed to help teenagers improve their self esteem, broaden their sense of job opportunities, and teach them skills needed to make a successful transition to the labor force; (c) school-based programs designed to prevent school-drop and improve school achievement among populations at risk of teenage childbearing which also began to be promoted as indirect strategies to achieve pregnancy prevention.

During this period, for the first time, national minority organizations began to become involved in developing community education and awareness strategies specifically targeted at minority youngsters and their families, often using church organizations as a base.

Again, in response to the influence of individuals and organizations with more conservative values, many sex and family life education curricula, public awareness campaigns, and family planning clinics began to include an emphasis on promoting sexual "abstinence" for unmarried teenagers as the most effective prevention strategy of all.

Increasingly, the important role parents played in transmitting values to their children and communicating about sexuality was acknowledged and parents too became the target of many prevention efforts. And finally, belatedly, the role of the male partner involved in teen pregnancy began to be acknowledged in a few of the public education and awareness campaigns which focused specifically on "male responsibility", and in the sexuality and family life curricula and life options programs. However, there is, as yet, only minimal emphasis on males in family planning programs. This emphasis on the male role in pregnancy prevention may grow but more as a result of a commitment to AIDS prevention than teen pregnancy prevention.

Evolution of services for pregnant teens and teen parents

The decade has seen a similar broadening of policy focus designed to meet the needs of pregnant teens and teen parents. The initial programs in the seventies targeting pregnant teenagers and teen mothers focused primarily upon their health needs, assuring adequate pre- and postnatal care and pediatric services for the young woman and her infant. By the late seventies, in growing recognition of this population's multiple, interrelated needs, teen pregnancy programs offered directly, or through referral, a much more comprehensive package of services to include: continued schooling, income support, parenting education, vocational and psychological counseling, family planning (to prevent second births), family counseling, transportation, nutrition services, child care and, sometimes, housing. In the early eighties, Conservatives added an emphasis on adoption counseling to this broad agenda.

As a result, "comprehensiveness" and linkages with other services became the watchwords for successful teen parent programs. And case management became the "glue" that was designed to put all the pieces together and ensure the teen client did not get lost in the maze. These community-based programs were funded through multiple public and private sources and were characterized by flux and instability as a result. The majority were targeted on low-income communities with high rates of teen pregnancy and childbearing, initially in urban areas although increasingly programs began to be set up in rural areas as well.

By the mid-eighties, many programs were striving to incorporate new components and emphases. Many attempted, in an ad hoc fashion, to reach out to include the male partner of their teen clients, usually, a young man with multiple needs for services himself. And many programs began to include various family involvement strategies, working directly with the teen girl's family---the baby's grandparents---with whom she usually lived and remained dependent upon, in order to maximize their support.

The public dependency issue. By the late eighties, new research findings emphasized the fact that teen parents are those at greatest risk of long-term dependency on public welfare assistance. These findings combined with a change in public values and attitudes towards maternal employment and public dependency is causing a major shift in policy strategy towards the majority of teenage mothers who receive public assistance.

The Family Support Act of 1988 requires AFDC teen mothers who have not completed high school to enroll in continued education and training, and all teen mothers to enroll in the Job Opportunities and Basic Skills (JOBS) program, no matter how young her baby (as long as appropriate child care was available, etc.). (For details of the Act's requirements and various support services, see Ooms, Golonka and Herendeen, 1990.) Other older welfare mothers are exempt from required JOBS participation if they have a child under three years of age, or at state option, under one year.

The Family Support Act also places more emphasis on the unwed fathers' financial responsibility in two ways. First, through strengthening child support collection procedures and second, it hopes to increase rates of paternity establishment by requiring that both parents social security

numbers be registered at the time of the child's birth. Many questions remain about the extent to which states will in fact focus on the teen parent portion of the welfare population as they implement the Family Support Act and about the ability of welfare agencies to work collaboratively with education agencies. (These issues will be the subject of a seminar to be held later in the year.)

Federal role and leadership

These broad policy and program shifts and expansions have occurred at all levels of government and have developed in an ad hoc, somewhat piecemeal, fashion. To what extent has the federal government provided a leadership role in these developments?

In 1977 during the Carter Administration, Joseph Califano, HEW Secretary, established an interagency task force to review the scope of the problems of teenage pregnancy and develop a government wide strategy for teen pregnancy. The task force report emphasized primary prevention, including sex education, as well as improving services for pregnant teens and teen parents. And a broad legislative package was proposed which included additional funding for family planning, maternal and child health, and the development of health education curricula. However, only a portion of these proposals were enacted, chiefly the adolescent grants program, touted by Califano as the "centerpiece" of the government's teenage pregnancy strategy. And this bill was amended by the Congress to de-emphasize the primary prevention services which had been included in the original proposal.

In the Reagan and Bush administrations there has been no comparable federal effort to develop a broad, comprehensive teen pregnancy strategy. Although a new version of the grants program was proposed by Senator J. Denton (R-AL) and enacted in 1981, and became known as the Adolescent Family Life Program (see page 8). The issue of teenage pregnancy received substantial visibility during the eighties and has been the subject of considerable controversy since federal regulations were put forth regarding parental notification and consent for family planning. And when, in 1981, abstinence became a feature of the grants program---dubbed by the media as the "chastity" program--- and when the constitutionality of the grants program was challenged in court over the church/state issue.

In 1986, HHS Secretary Otis Bowen set up a panel on teenage pregnancy prevention, but the Secretary was convinced that "it was community-based approaches, not a national program, that would be most successful in reducing the incidence and consequences of teenage pregnancy" (Family Support Administration, 1989, p. 6). Hence the Panel's report focused on what could be done at the community level and avoided any discussion of, or recommendations about, the federal role in prevention.

Congressional action on this issue has focused somewhat narrowly on the Adolescent Family Life Program whose fate became linked with the conflicts over the Title X family planning program. Democrats in the Congress, objecting to several of the new features in the 1981 Act, fought to retain the funding levels and federal control over the Title X family planning program. And the late Congressman Mickey Leland proposed a program which would expand funding of comprehensive services to teen parents. There has been a good deal of congressional interest in the issue of combating the high rates of infant mortality. A National Commission on Infant Mortality was established in 1987, under the Chairmanship of Senator Lawton Chiles, and legislation was introduced in 1989 but the role of teenage pregnancy in this problem has not received much explicit attention.

The National Academy of Sciences, Panel on Adolescent Pregnancy and Childbearing, engaged in a comprehensive review of related research and in its report, published in 1986, did spell out broad general goals for public and private sector policy. However, the report did not discuss in any

detail ideas about state and federal government roles, nor did it recommend specific changes in current federal programs or new legislation (Hayes, 1986).

Many believe that the controversies about abortion, contraceptives, parental notification/consent, and "abstinence" which so often entangle teenage pregnancy prevention strategies have paralyzed leadership at the federal level not only on primary prevention strategies but on broader secondary prevention issues as well. At the state level however, as will be described on pages 10-16, several states have managed to side-step these controversies and succeeded in setting forth comprehensive goals for statewide teenage pregnancy-related policy and specific strategies for achieving them.

INVENTORIES OF FEDERAL PROGRAMS RELATED TO TEEN PREGNANCY AND EARLY CHILDBEARING.

The broad scope of policy related to adolescent pregnancy creates a somewhat daunting challenge for federal and state policymakers. How can decisions be made about priorities? How can the efforts in one program area be assured of complementing and reinforcing those in another?

The first step in the development of comprehensive and coordinated policy at any level is to undertake an inventory identifying specific programs that 1) affect adolescent pregnancy and childbearing and 2) provide services to assist pregnant adolescents and teen parents and their children. Such an inventory is useful for several reasons.

---It clarifies the scope of current policy and identifies those programs that need to be critically assessed with respect to how they contribute to teen pregnancy prevention and how adequately they meet the needs of pregnant teens and teen parents.

---It can help identify the gaps in services.

---An inventory can suggest where there may be duplication, overlapping, and coordination problems between programs.

---From the states' point of view, a federal inventory helps to identify sources of funds that can be tapped by states for strengthening existing programs or financing new state initiatives.

Moore's Inventory. The first published attempt to develop a comprehensive, descriptive inventory of such programs at the federal level was made by Kristin Moore who identified, and briefly described, approximately thirty-five separate programs in five federal departments---HEW, Labor, Agriculture, HUD, and Defense---that existed in 1978 that were related to teenage family formation and functioning (Moore, 1981). Only one of these programs explicitly targeted the teen pregnancy population, but all of them in one way or another provided services that affected, or could influence the incidence and the outcome of teenage pregnancy.

The programs in this inventory included a range of activities such as financing health care and social services, providing direct services, funding demonstration programs and research, training, and evaluation efforts.

As Moore pointed out, although these programs' potential for serving adolescents is real, and a few specifically target a portion of their funds to teenagers and teen families, it is often very difficult, or impossible, to find out how many teenagers or teenage parents are in fact served by these programs. This is because federal programs do not usually collect, and/or regularly report on, the ages of the clients they serve and/ or their family status. For example, there is no data

available on the parental status of youth served in job training and employment programs. Moore also cautions that the inventory she developed was time-bound and would need regular updating.

Indeed when Moore herself undertook such an update in 1983, an inventory which focused solely on programs that served pregnant teens and teen parents, her listing grew from 35 to approximately 50 programs (Moore, 1983).

Not everyone agrees on which programs should be included in such an inventory. For example, some would not include early childhood education programs or middle grades school improvement programs in teenage pregnancy policy. The House Select Committee's 1986 report listed only eleven federal programs which address some aspect of teen pregnancy (Select Committee, 1985).

Many states have informally constructed their own catalogues of federal and state programs as part of their development of a teenage pregnancy initiative. One such inventory, conducted at the request of a committee of the National Governor's Association, identified nearly 50 federal programs existing in 1987, that could provide money to help states fund health education and social service programs to prevent adolescent pregnancy and assist in teen parenting.

On page 21 we provide a **Summary listing of federal programs that are related to teen pregnancy and parenthood.** This listing adapts and updates Moore's inventories. It is by no means exhaustive and does not attempt to describe the programs in any detail, discuss the numbers of adolescents they serve, or the nature of these programs' effects on teen pregnancy. Moreover, we do not identify all the different small programs within each program area. For example, there are at least 22 federal programs and tax provisions that provide some type of child care assistance, all of which could presumably be of assistance to teen parents; we only list the major ones (see Ooms and Herendeen, April, 1989).

We have organized this inventory, as Moore did, by major program area---health, education, income support, employment and training, and social services. An alternative typology would be to categorize programs by the goals/ or type of impact they have (or could potentially have) on the teen pregnancy problem. However, several programs meet different objectives, and thus would appear in several places on the list. For example, early childhood programs, such as Head Start, can be viewed on the one hand as a service to the children of teen parents and on the other hand as an indirect strategy to prevent preschool children themselves becoming pregnant as teenagers. (Longitudinal studies have indicated that effective compensatory education programs like Head Start have a positive effect on reducing rates of teen pregnancy.)

This listing obviously parallels similar inventories at the state level where federal programs are often supplemented with state dollars (and of course, private-sector dollars also).
It is important to note that there are two types of teen pregnancy related services that are absent from the federal listing. First, there is no listing for abortion services since the 1977 Hyde Amendment to an HEW appropriations bill, which has been enacted every year since, forbade any federal funds from being used to fund abortion or abortion-related services. In spite of the lack of federal funding for abortions, the teenage abortion rate has remained approximately at the same level since 1981 (Henshaw and Vort, 1989), although there are reports that in some states teenagers are obtaining abortions later in their pregnancy as a result of the increased difficulty in accessing abortion. These abortions are financed largely through private monies and with state funds in those thirteen states which permit using state funds for abortion

Second, since education is primarily a state and local responsibility, the federal government has played a very minimal role in school-based sex and family life education programs, and also a minor role in the public education/ community awareness prevention campaigns.

TEENAGE PREGNANCY LEGISLATION IN THE 101ST CONGRESS

The Adolescent Family Life Program

Enacted in 1981, the Adolescent Family Life Program authorized under Title XX of the Public Health Service Act, was a refocusing of a teenage pregnancy grants program started under President Carter in 1978. Like its predecessor, the program is administered by the Office of the Assistant Secretary for Health within the Public Health Service. However, an administrative layer was added in 1983 when the AFL office was conjoined with Title X family planning under the Office of Population Affairs. Key components of the 1981 program stayed the same but several important new emphases were added. The program would continue to give grants to public and private, non-profit, community-based organizations to provide comprehensive health, education, and social services for pregnant teens, teenage parents, and adolescents at risk of pregnancy.

The new features included in the 1981 legislation were: a much stronger emphasis on serving adolescents in their family context; a stronger emphasis on prevention methods promoting self discipline and abstinence; a stronger emphasis on research, evaluation, and dissemination; and requiring programs to emphasize adoption as an option to an unwanted pregnancy.

In keeping with a philosophy that the Federal government should get out of the business of providing basic services funding for social programs, the Reagan administration envisioned these AFL projects as five-year demonstration projects to learn about what works for teenage pregnancy prevention. Special attention was given to programs encouraging teens to postpone sexual activity. Federal funding for these demonstration projects was intended to cease after five years.

Since 1981, the AFL Office has funded over 140 demonstration projects and several dozen research projects. About 1/3rd of the projects focus on prevention, the others provide services to pregnant teens and teen parents. In the early 1980s, AFL awarded a number of their grants to religiously affiliated organizations. The AFL law was attacked in court as a violation of the constitution's separation of church and state. While the Supreme Court upheld the constitutionality of the AFL program on its face, it said it had the potential to be unconstitutional in its application by the grantees, that is if their activities promoted religion.

The program's authorization, which expired in 1985 and has been continued at a low funding level ($9.5 million in 1988 and 1989) through continuing resolutions passed each year by Congress, has caused much uncertainty among the programs. The major thrust of new legislation presently pending in Congress is to change this program from its temporary status to a properly authorized program that will receive regular funding.

Current pending legislation

Congress is attempting to reauthorize and revise the AFL act with two bills. S. 120 sponsored by Sen. Kennedy (D-Mass.) and H.R. 5246 known as the Leland bill, named after the deceased congressman, Mickey Leland (D-Tex) who introduced similar legislation in 1989. These two bills are similar except that the Leland bill expands the definition of eligible persons to include teenage men and teen fathers. Although the authorization level requested in these bills is $30 million in the Senate bill and $60 million in the House bill, the Administration has only requested $9.4 million in appropriations and the expectation is that it will be reauthorized at this, the present level. In addition to providing needed stability, the bills try to improve the AFL program in several ways.

First, the new legislation will delete the controversial parental consent provision. Under the AFL programs, teens are required to get approval of a parent or relative in order to receive services. Advocates insist that this provision creates a barrier to needed services. The new legislation would encourage parental approval, but not make it mandatory.

Second, in response to the church/state controversy, the new legislation attempts to ensure that the government fund non-value based programs by emphasizing that programs have to mention the full range of services including contraception. The bill also contains an informed consent provision whereby teens who are pregnant are informed of all their options. A counselor can tell a teen who does not want to carry her pregnancy to term that she has options, but the counselor cannot refer her specifically for an abortion.

Third, under the Title XX legislation, federal funding of a program was expected to be discontinued after five years. The new legislation assumes that these programs will continue to need federal funds which can thus be provided for longer than five years, although it encourages them to use different funding streams such as state funds, private sources like the United Way, and private health insurance.

Evaluation. AFL has always had a strong emphasis on evaluation and grantees are required to conduct evaluations of their services using between 1-5 percent of their grant. However, these monies were found to be grossly insufficient. For small programs with little evaluation experience, evaluation has proven difficult and impractical. The new bills attempt to strengthen the research component by providing more funds for evaluation and allowing more flexibility. The new infusion of funds for studying the effectiveness of programs is being applauded by advocates as a much needed change. If the new legislation is passed, each program that is granted funds may use up to 10 percent for evaluation. Further, programs can pool their money for multi-site evaluations in order to conduct more effective and comprehensive studies.

The administration does not see the need to make any revisions in the AFL Act and is opposing the changes proposed in the Kennedy and Leland bills and has introduced a bill to reauthorize the program in its present form. The Administration bill is sponsored by Senator Orrin Hatch (R-UT) and Representative Edward Madigan (R-IL). The administration opposes the Democrats' bills for several reasons: the increased funding level; a fear that they represent a shift in emphasis away from abstinence toward family planning; the deletion of the existing requirement that grantees obtain parental consent; the elimination of restrictions on abortion counseling and referral; and the de-emphasis of adoption as an option for an unwanted pregnancy.

The Healthy Birth Act of 1989

The Healthy Birth Act of 1989, HR 1710 was introduced in April 1989 by Representatives Rowland and Tauke, and Senators Bradley and Durenberger in the Senate. This legislative proposal incorporated several of the recommendations of the National Commission to Prevent Infant Mortality including increased home visiting, "one-stop shopping", toll-free information and referral numbers, required the HHS Secretary to distribute a maternal and child health handbook to all new parents nationwide, and to develop model Medicaid-WIC joint eligibility packages for use by all states. This proposal was not enacted but pieces of it have been picked up and incorporated into various bills introduced in 1990.

Although these proposals have been developed to improve federal maternal and child health policy, they should be regarded as adolescent pregnancy prevention policy as well since adolescent pregnancies and births contribute a significant portion of the problem of infant mortality and morbidity (National Commission Issue Brief).

TRENDS IN STATE POLICY

(Sources: Biesmesderfer, *et. al.* 1989; Kenney & Somberg, 1989; Koshel, 1990; Select Committee, 1985; Southern Governors' Project, 1989 & 1990)

Several reports in recent years have documented the fact that adolescent pregnancy and parenthood is an issue that is rising high on the policy agenda in the vast majority of states. The most recent of these, published by the National Governor's Association, concludes that "states have made considerable progress in implementing programs and policies to reduce the incidence of adolescent pregnancy and parenting. During the past four years, more than two-thirds of the states improved their administrative ability to coordinate programs for at-risk youth. A majority now have executive and/or legislative task forces or some other formal mechanism for developing more effective policies...and many states have expanded their financial commitment..." (Koshel, 1990, p.ix).

The Alan Guttmacher Institute conducted an assessment in 1988 of the twenty-five states which had launched initiatives on teenage pregnancy in the 1980s, initiatives proposed by legislative, gubernatorial, and administrative entities. It defined an initiative as "a reasonably comprehensive proposal to address the problem" (Kenney and Somberg, 1989). In this report the authors compared the content of the legislative initiatives and the published recommendations of executive branch initiatives with the recommendations of the National Research Council Panel's report, *Risking the Future*. The AGI report points out that only a few of these state initiatives focus on family planning, which was the major recommendation of the NRC Panel, and there was very little mention of alternatives to teen childbearing, namely adoption and abortion.

Recent trends in state legislation

The National Conference of State Legislatures reported on their 1988 survey of states' legislation related to teen pregnancy and found that "teenage pregnancy and parenting have received substantially more attention in the past two years than ever before in state legislatures. A total of 275 bills related to the problems were introduced in 1987 and 1988...by the end of 1988, teenage pregnancy legislation has been enacted in 38 states, compared to only nine states three years ago" (Biesmesderfer, *et. al.*, 1989, p. 1).

Although the various bills introduced in the state legislatures represented a wide range of philosophies and approaches, together they reflect a concern with both primary and secondary prevention. However, few state legislatures have addressed any "comprehensive" proposals. The legislation also reflects some of the current controversies. According to the NCSL report, since 1985, the most frequently enacted types of legislation, in order of frequency, were: parental consent or notification for abortion; family life or health education; legislative task forces, committees, or studies of the problem; alternative education/drop-out prevention strategies; and maternal and child health.

Education Legislation. State bills emphasize four types of prevention strategies---family life education (these broad curriculum usually emphasize a comprehensive approach to teaching about human sexuality and related topics and includes a focus on decision-making skills and positive role-modeling); health education (usually a narrower curriculum sticking to the "facts" of human sexuality and sexually transmitted diseases); alternative education/dropout prevention targets "at-risk" youth---including those who run away from home, are sexually active, involved in drugs, and failing academically; comprehensive education, outreach and support programs often targeted on providing community-based information and support services for young parents such as bills passed in Connecticut and Tennessee.

Health Care Legislation. Many states are introducing legislation related to parent notification and/or consent for abortion for unemancipated minors, which is a highly controversial issue and hence has often become a subject for legal action. Twelve states introduced bills in 1988, and three were enacted, but all three are being held up through litigation or court injunction. Of the seven states passing such bills in 1986 and 1987, five have been under court injunction since the time they were scheduled to go into effect. 1988 also saw an increase in legislation to prohibit dispensing of contraceptives to minors in schools and community clinics.

Other less controversial types of health legislation include funding for programs to provide comprehensive health care for the teenager's prenatal and postnatal care, and the infant's care. No laws were enacted in the states to provide increased funds for school-based health clinics however, although there are now over 100 such clinics across the country.

Social Services Legislation. The focus of states' social services legislation paralleled developments at the federal level in that various proposals aimed to help parenting teenagers attain financial independence. One relatively new trend was grandparent responsibility laws---bills that required financial assistance or insurance coverage from the parents of minor adolescent parents. (Wisconsin's Act of 1987 is the best known.) In addition, a few bills funding job training, child care, and case management services for teen parents were enacted. Seven bills were also introduced in 1988 to improve the coordination of programs for teenage parents, only three were enacted.

Legislative Task Forces, Commissions, Boards and Studies. By 1988, 18 states had created legislative study groups to examine either particular aspects of teenage pregnancy issues or the issue as a whole. For example, the Louisiana Act establishes a commission "to develop a statewide comprehensive, coordinated plan to reduce teenage pregnancy. The plan is required to integrate health and parenting programs with educational and vocational counseling programs" (Biesmesderfer, *et. al.*, 1989, p. 5).

State executive branch policies

The National Governor's Association in spring of 1990 issued a report which updated its 1985 report of what states were doing in teenage pregnancy. In three years it noted considerably increased activity and many changes in a positive direction. In two surveys, in 1988 and January 1990 NGA collected data in four program areas: how the states organized to address the problems of teenage pregnancy and new actions in health care, education, and employment and training programs (see Table 11 for a summary, p. 31).

Organization. Joint planning and interagency coordination were clearly important tools in developing comprehensive state strategies for addressing teen pregnancy. Since 1985 the NGA report found that more than two-thirds of the states had made progress in how they are organized. The number of states which had some kind of coordination mechanisms or structures in place grew from seven in 1985 to 17 in 1990. The report points out however that it is possible to administer an impressive array of programs without having any coordination mechanism in place (such as Michigan). By 1990 only two states provided no policy guidelines or resources to local communities to deal with the problem (down from eleven in 1985).

Health. Many states put considerable state dollars into family planning services, notably through matching federal Medicaid dollars. Thus the combined levels of federal/state financial support for family planning stayed about the same in real terms throughout the eighties although federal Title X dollars declined. Thirteen states provide financial support for school-based clinics through a variety of existing programs. (These clinics provide family planning services, usually by referral, but the majority of students' visits are for other health related services.) The issue of school-based

clinics dispensing contraceptives is highly controversial. New Jersey has expanded the school-based clinic concept and set up comprehensive centers which provide a variety of health services to youth in addition to job-readiness counseling and training, remedial education, and drug and alcohol counseling.

The most significant recent state health action is the steps that nineteen of them had taken by January 1990 to expand their Medicaid programs to cover pregnant women and young children above 133 percent of the federal poverty line.

Education. The NGA report examines four areas in which states are strengthening their educational systems, which may have short-term or long-run effects on teen pregnancy prevention: early childhood education---which about half the states are putting increased resources into; improving education in the middle grades; programs focused on older, "at-risk" youth (26 states have developed statewide initiatives in this area); and family life education.

The Alan Guttmacher Institute surveyed the states with respect to their activities in sex and family life education. States have clearly dramatically increased their activity in this area. In 1980 only three states required that sex education be taught in public schools. By 1988 seventeen states had such a requirement. However, the content of the curriculum varies widely and is seldom comprehensive. Fewer than two-thirds require or encourage the schools to teach about contraception. The survey report suggests that the impetus for this increased activity in such a controversial area is primarily a response to the public health concerns arising from the AIDS epidemic (Kenney, Guardado & Brown, 1989).

Employment and Training. The NGA report states that by January 1990 15 states had already invested state funds to develop or enhance special employment and training initiatives for at-risk youth, and fourteen states made some provision for child care for teen parents. By October 1, 1990, as a result of the Family Support Act of 1988, all states will be required to have in place special education/ training programs and child care for many, if not most, teen parents on welfare. (The NGA report does not have any information about how states are planning to put these programs into place.)

THREE EXEMPLARY STATE INITIATIVES

Among the many states which have strong statewide initiatives on teenage pregnancy we have selected three to report on here which exemplify different approaches: Illinois, where the initiative and leadership comes from the coordinated efforts of three state agencies; Maryland, where the original and ongoing initiative and leadership comes from the Governor's Office; and North Carolina, where the initiative and leadership is provided by a statewide coalition of private sector agencies. In each of these states certain activities have been carried out as a result of private/public partnerships, with funding from private foundations and other sources. Also certain activities required state legislative action.

Parents Too Soon, Illinois

Illinois was the first state to launch a comprehensive, statewide teen pregnancy initiative, Parents Too Soon, to which it now commits major federal/ state funding, $17 million in fiscal year 1991. The unique approach of Illinois' initiative is to build on the collaborative leadership and funds provided by three lead government agencies, harness the cooperation of another seven state

agencies and involve local community organizations and a private foundation to pool resources and talents.

The origin of Parents Too Soon (PTS) goes back to 1980 when the Conference of Women's Legislators held a series of hearings on adolescent pregnancy and parenting. From the findings and recommendations of these hearings, the Illinois Department of Public Health formed a task force whose report became the blueprint for action. Based on this report, the Republican Governor J.R. Thompson, launched Parents Too Soon in 1983. At that time in Illinois there were many organizations dealing with parts of the teenage pregnancy problem, but there were many gaps in services which left too many teen parents and their children unserved. The primary purpose of the project was to fill in these gaps.

Structurally, the statewide project comprises the consortium of three lead state agencies who agree to pool funds and engage in coordinated planning. These agencies are the Departments of Public Health, Public Aid, and Children and Family Services. The Directors of these three agencies meet quarterly to oversee program direction and set policy. The project is administered by a program Administrator, who is housed in the Department of Public Health. Parents Too Soon coordinates with the teen pregnancy efforts of seven other state agencies: the Departments of Commerce and Community, Alcoholism and Substance Abuse, Mental Health and Developmental Disabilities, Employment Security, State Board of Education, The Governor's Planning Council on Developmental Disabilities, and the University of Illinois' Division of Services for Crippled Children. Projects are funded primarily from four major sources of federal funds supplemented by state funds in the ratio of approximately $5 federal to every $1 state dollar. Project funds are disbursed to over 125 local, community-based public and private agencies which are the "focus and heart" of the project. These organizations design and operate the programs to suit their local needs and resources.

The activities and achievements of the project to date can be summarized under the three project goals.

1) *To reduce the incidence of teenage pregnancy.* In 1987, approximately $3.7 million of the $12 million total project budget was spent on public awareness, community involvement, and preventive education efforts to meet this first goal of PTS. 55 groups received PTS prevention funding. Activities sponsored by these groups included numerous teen leadership conferences, public service announcements, a poster campaign, a 12 minute documentary and a teen song writing contest, and a PTS hotline, staffed seven days a week from 9 a.m.-11.30 p.m.

In recent years Illinois' overall teen birth rate has remained about the same although there has been a slight decrease in the white and Hispanic birth rates. The rates for married teens have decreased sharply but are offset by an increase in the rate for older, unwed teenagers, ages 18-19 years.

2) To reduce the health risks to mother and baby of teenage pregnancy. In 1987, PTS allocated approximately $4 million of its overall budget to improve the health of the babies and mothers. These monies were spent on WIC programs (Special Supplemental Food Program for Women, Infants and Children); thirty prenatal care programs, three comprehensive demonstration programs (targeted on communities with high rates of unemployment, teen births and infant mortality); and provides some funding for four school-based health clinics. In those programs providing comprehensive, accessible services with a case management component, birth outcomes have been significantly improved, i.e. fewer low-birth weight infants born, few complications at delivery, and very few (if any) infant deaths.

Illinois has five school-based comprehensive health clinics which became embroiled in the controversy centered around parent consent and provision of family planning services. The PTS policy has been to leave these decisions to the local community---the parents and residents

themselves. With the result that all the clinics have some form of parent consent for services and only two of the clinics prescribe and dispense contraceptives, two neither prescribe nor dispense and one prescribes but does not dispense (PTS, 1988).

3) To improve the teen parent's ability to cope with the responsibilities of parenthood. About $3.2 million of the 1987 PTS budget was allocated to a variety of services aimed at improving eventual self-sufficiency and the quality of parenting. Two of the lead agencies joined forces with the Ounce of Prevention Fund, a project funded by the Pittway Corporation Charitable Foundation to fund and administer the Young Parent Program---a voluntary job training and basic skills development program which also provides support services such as child care and transportation. The initial positive results of this program---65 percent of participants achieved or were moving towards self sufficiency---led to the launching of the federally funded Teen Parent Demonstration project, Project Advance which required participation in a similar program for a sample of teen AFDC recipients.

Activities also involving the Ounce of Prevention Fund focus on thirty-seven community based programs providing home visits, parent training, developmental child care and support and education to extended family members all designed to improve parenting, reduce child abuse and neglect, delayed development, and repeated cycles of teenage pregnancy.

Currently, PTS is undertaking a study to evaluate the impact PTS programs have had on Chicago's west side. The study will address such questions as: what is the impact of the PTS program upon school completion and educational plans? What is the impact upon receipt of needed medical care, AFDC, and on subsequent childbearing? The study will evaluate three different programs, attempt to meet the evaluation needs of three different state agencies and collect, integrate, and analyze the multiple kinds of data from multiple sources. Results should be available by the summer of 1991. The study will be conducted by Dr. Douglas Kirby, of ETRA Associates.

Contact: Linda Miller, Administrator, Parents Too Soon, Illinois Department of Public Health, 535 West Jefferson St., Springfield, IL 62767 (217) 782-0554

The Governor's Council on Adolescent Pregnancy, Maryland

The Governor's Council on Adolescent Pregnancy was created in 1986 as a result of the Governor's Task Force on Adolescent Pregnancy. This Task Force made a series of recommendations to reduce the incidence of teen pregnancy. One recommendation was for the establishment of the Governor's Council on Adolescent Pregnancy.

The Council's 18 members, appointed by the Governor, include cabinet secretaries, members of the General Assembly, representatives from the community, academia, and local government. The Council meets six times a year, and sets broad policy. The activities of the Council are carried out by an executive director and five person staff. Funding was provided for five staff positions, which has been augmented to seven full-time staff positions and one part-time employee.

The mission of the Council is the reduce the incidence of unplanned adolescent pregnancies in Maryland. The Council is mandated to mobilize public and private resources, and coordinate planning and program policy development and service delivery both to reduce teen pregnancy and to promote positive outcomes for pregnant and parenting teens and their children. Council staff conduct a wide range of information, advocacy, and policy-related activities including an ongoing public education campaign using fact sheets, resource directory, and a Speaker's Bureau to educate and update Marylanders about teen pregnancy and its prevention. The Council convenes hearings, and provides technical assistance to local governments and the community.

The main thrust of the Council's activities to date have been focused on primary prevention and its success is a tribute to its ability to respect the values and sensitivities of all its citizens without being captive of any one group. It has balanced efforts to promote postponement of teen sexual activity and parent's role in sexuality education with an expansion of family planning services for teens. Its major achievements to date include the following.

---Developed a comprehensive plan of action and specific strategies to implement the goals of the Council, summarized in a report "Action 90".

---Secured $4 million in funding for an expansion of family planning services for teens to include education, counseling, outreach, and contraception.

---Secured funding to put in place a case management program for "at-risk" pregnant and parenting teens.

---Initiated and implemented a $250, 000 Community Incentive Grants program to encouraged community-based public and private efforts.

---Developed and coordinated PACT (Parents and Children Talking), the statewide public awareness campaign, to promote the role of parents as the sexuality educators of their children.

---Launched a multi-million dollar media initiative, "Campaign for Our Children" which is aimed at youth between the ages of ten and fourteen. Using mostly privately raised funds, a public relations firm has prepared posters distributed in schools throughout the state and radio and TV public service announcements.

---Conducted a survey of family planning clinics to determine the extent and nature of their services to sexually active teenagers. As result, several recommendations were made to the Governor and General Assembly about ways to increase the accessibility of these services to teens such as reducing the waiting period for appointments, extending the hours to weekends and evenings, accepting walk-ins, reducing fees, and engaging in more outreach activities.

---Plans to conduct an examination of family life education programs and the child support program to make recommendations for changes in these programs.

Contact: Bronwen Mayden, Executive Director, Governor's Council on Adolescent Pregnancy, Department of Human Resources, 311 West Saratoga Street, Room 260, Baltimore, Maryland 21201. 301-333-0270

The North Carolina Coalition on Adolescent Pregnancy

The North Carolina Coalition on Adolescent Pregnancy (NCCAP) provides a vigorous, innovative, and highly successful example of private sector and volunteer approaches to teenage pregnancy in a state with very high rates of teen pregnancy. "Each day in North Carolina 75 teenagers get pregnant, 28,000 each year. 50 percent will become teen parents, 40 percent will choose abortion, and 75 percent are out-of wedlock pregnancies" (NCCAP, 1989). North Carolina's infant mortality rate is rising and is the highest in the nation and the state has the lowest scores on standardized school achievement tests. It is also a state in which there are well-entrenched and powerful conservative attitudes which has led the Coalition to develop some creative ways of bringing together people who have diverse values.

The Coalition was originally convened in 1974 as a task force of the United Way of North Carolina and opened a state office in 1986. Professional staff carry out the goals and objectives determined

by a 30-member Board of Directors who represent local councils on adolescent pregnancy prevention, private agencies, volunteer organizations, state departments, and public agencies. It is supported financially with funds from local United Ways, private foundations, special events, grants from the legislature, and private contributions.

The mission of the Coalition is to create awareness of the need for prevention, broadly defined, and to mobilize and support local, community-based resources to work cooperatively on prevention activities through providing information and education, training, technical assistance, and consultation. It also aims to influence public policy through monitoring legislative and administrative actions and providing information to elected officials. The Coalition conducts meetings and conferences throughout the state; publishes a regular quarterly newsletter; maintains a library and resource center of publications, films, videos, and other materials and itself publishes numerous reports. Its many activities and achievements to date include the following.

---Sponsorship and support of 46 local adolescent pregnancy prevention councils.

---Successful advocacy of state legislation in 1989 and again in 1990 that has provided seed money for 34/26 pilot community teen pregnancy prevention projects. Many of these projects were built upon the Mecklenburg county program model.

---Conducted a one year "Action Agenda" project which, with the help of an advisory panel of statewide leaders, conducted a statewide survey of over 250 service providers; held three focus group meetings with teens; surveyed 127 pregnant and mothering teens, and held seven regional Task Force meetings. Based on the findings of these activities, the Coalition published a report in 1989 making extensive recommendations for action for every sector of the state community including elected officials, schools, social services, medical providers, community groups, religious organizations, corporations and the media (NCCAP, 1989).

In addition to continuing their data gathering and technical assistance activities, the Coalition's current plans for future activities include conferences for the clergy and media and a large statewide conference for youth, called Teen to Teen.

Contact: Barbara Huberman, Executive Director or Mia Day Burroughs, Public Education Coordinator, North Carolina Coalition on Adolescent Pregnancy, 1300 Baxter Street, Suite 171, Charlotte, North Carolina 28204. 704/335-1313.

WHAT MORE CAN THE FEDS DO TO HELP?

(Sources: Koshel 1990; National Commission, 1988 & 1990; Southern Governors' Association, 1990; Schorr, 1986)

The federal government provides the large majority of funding for the state initiatives in teenage pregnancy prevention and services, with the exception, as noted, of community education and awareness activities, sex and family life education programs and abortion services. Is the type and levels of current assistance sufficient? What more can the feds to to help?

Recommendations for the federal agenda

Most policy discussions about teenage pregnancy conclude with recommending increased program funding and a broader array of activities by all sectors of society. This is undoubtedly because "the problem" has not significantly diminished and society is gaining a greater appreciation of its

complex ramifications. Few of these reports however discuss in any depth the nature of the federal government vis-a-vis the state governments' role in teenage pregnancy prevention or in services for pregnant and parenting teens. The following ideas and recommendations for the federal government emerge from a review of recent reports and discussions with experts.

Increased federal funding. Almost every study and report on the subject of teenage pregnancy argues for increased funding in the major federal programs since the problems of teenage pregnancy continue to be widespread. For a variety of reasons there is not a lot of data available to document the extent of unmet need. It is clear that many adolescents who are near-poor are without medical insurance, which severely limits their access to needed medical care. Hence the Sixth Omnibus Budget Reconciliation Act of 1986 (SOBRA-86) Medicaid expansions were much welcomed by advocates. Many of the issues about access and availability however have to do with the design of services---for example, there are many reasons that are not related to ability to pay to explain why so many teenagers do not use family planning clinics or young pregnant women do not use prenatal and postnatal care even when they do exist in their communities.

Programs may need both increased resources and increased flexibility to be able to provide the kinds of outreach, home-based services many young mothers need, as has been demonstrated by the Healthy Mothers and Healthy Babies programs funded by Title V, Maternal and Child Health program (Coates & Maxwell, 1990; National Commission, 1989). There is also a growing interest in "one-stop shopping" centers for maternal and child health care services. In the long run, placing various related services in one location, and simplifying and centralizing application, eligibility, and follow up procedures should not increase, but might diminish costs. However, in the short run, increased resources may be needed to mount trials of such new service delivery arrangements.

Increased technical assistance. Many states and localities have to "invent the wheel" when developing new comprehensive teen pregnancy and parenting programs. Many wish that the federal government would fund or provide technical assistance and consultation to help these programs build on the best knowledge available. The technical assistance resources of the federal Adolescent Family Life Program are extremely limited; program staff can do little beyond basic monitoring of their funded programs. The private sector National Organization of Adolescent Pregnancy and Parenting Programs (NOAPP) also has limited ability to provide on-site, individualized assistance to programs although it does conduct workshops and conferences.

Improved dissemination of research findings. The federal government has been funding basic research on the causes and consequences of adolescent childbearing, and many evaluations of teen pregnancy and parent programs for more than a decade, largely through research grants administered by the National Institute for Child Development Research and the Adolescent Family Life Office. At present there is no regular systematic vehicle for summarizing and disseminating the results of these studies and their implications for state and local policy and programs. A private sector newsletter disseminated to hundreds of programs and professionals in the teen pregnancy field *TEC Networks,* funded by the Mott Foundation, does periodically share the lessons of research (see TEC Networks June 1990).

Again the dissemination resources of the AFL Office are extremely limited, as are the resources and expertise of Project SHARE, the federally funded clearinghouse which distributes publications related to adolescent pregnancy as well as on other topics. Federal funds have been invested, usefully, in establishing the Adolescent Pregnancy Data Archives which makes research data available to other researchers but does not summarize research findings for the non-academic community.

Curriculum development and funding of staff training. The effectiveness of services depends to a large extent on the knowledge and skills of program staff. Teenage pregnancy

program staff come from a variety of backgrounds, often with little prior experience working with adolescents and their families. Teen parent programs all suffer from tremendous turnover of line staff, supervisors, and program directors. To date, the only national attempt to develop a coherent training curriculum for teen parent program staff was mounted in the private sector by the Joseph P. Kennedy Foundation, Washington, D.C., which has developed and used in numerous training workshops a values-based curriculum for teen parent programs known as the *"Community of Caring."*

Training and technical assistance is provided in the federal family planning programs by the regional family planning centers, and many of these have sometimes focused on working with teen clients. The AFL Office has provided some national workshops on program evaluation and the new National NET project, funded by the Mott Foundation, provides technical assistance to programs on their evaluation.

Many believe it would be very useful if the federal government could fund the development of some training curricula that could be used and adapted for different client populations and settings. Organizations could then, under contract, be available to provide this training and technical assistance to teen pregnancy and parenting programs. (As is provided by the Tec*Net consortium in the early intervention field, for example, to help programs implement P.L. 99-457, Part H, and in the child welfare field through the nine National Resource Centers.) Funds would also need to be allocated in program budgets to pay for the needed in-service training.

Federal role in coordination

Coordination of programs and services is agreed to be a critical component of teenage pregnancy policy at all levels of government. Community-based programs struggle with this issue on a daily basis. Many states are developing mechanisms to improve coordination between different state programs. However, at the federal level there has been an absence of any formal efforts and mechanisms to improve coordination between the myriad numbers of programs that are involved with teen pregnancy.

Why is coordination so important? As our inventory makes clear, the current fragmentation of separate categorical services adds up to a "crazy patchwork" that creates enormous inefficiencies and frustrations for program administrators and staff and for the clients themselves. Each program has its own eligibility criteria, rules and regulations, reporting requirements, funding cycles, and bureaucracies. At every level, people working in one program do not know what the others are doing. Ideally programs should reinforce and complement each other, but in reality programs may duplicate, overlap, or pull in the opposite direction.

From the point of view of the clients themselves, failure to coordinate the variety of programs the teen mother, her infant, and other family members may need can be a logistical nightmare, and clearly explains why many teens do not use services available well or not at all. For example, simply establishing their eligibility over and over again for different health care and nutrition programs is time consuming, repetitive, and confusing.

States and localities are developing a variety of tools and mechanisms that interagency task forces or councils can use to improve the coordination of services in child mental health, foster care, and early intervention services including: interagency agreements for joint funding of projects, "pooling" funds, and negotiating "waivers"; common application forms, pooling staff resources and training, co-location of services, and so forth. Increased computerization should provide the technology to facilitate many of these efforts. These kinds of "tools" need to be employed in the adolescent pregnancy and maternal and child health field. However, often federal action is needed to remove barriers to these efforts and to encourage and facilitate them.

The need for improved federal coordination in child health was highlighted, and needed organizational reforms and mechanisms are discussed at length in the Report of the Select Panel for the Promotion of Child Health (Select Panel, 1981). Coordination of adolescent health programs is one of the major issues currently being studied by the current Office of Technology Assessment two year congressionally mandated study of adolescent health.

New federal/state initiatives in welfare reform, early intervention (P.L. 99-457), and maternal substance abuse---to mention only a few---will, or potentially could, have considerable impact on the pregnant teens and teen parent population. It is very important that the different programs and agencies involved become connected with those programs currently serving teen parents to ensure that their needs are well served by these new initiatives.

State governments are beginning to urge the federal government to take a more active role in coordination of teen pregnancy programs. The recent report of the Southern Regional Project on Infant Mortality---an initiative of the Southern Governors' Association and the Southern Legislative Conference---recommends that "the federal government should form a permanent interagency task force to coordinate federal programs which do or could impact adolescent pregnancy prevention. The task force should include representatives from all relevant agencies and departments and the private sector. Efforts should be made to link closely with state coordinating groups and prevention strategies. The task force should review federal prevention policies, funding for state and federal program barriers to services, and definitions of eligibility groups in federal programs, " (Southern Regional Project, 1989).

While the need for improved coordination is widely acknowledged, there are numerous attitudinal and practical barriers to achieving coordination which may appear quite insurmountable. Coordination too easily becomes a "buzzword"---in reality it may amount to no more than a group of individuals from different departments that meets to talk occasionally but achieves very little. It also, too often, may be considered a substitute for adequate funding.

If the federal government were to make a commitment to improve policy coordination, how could this be achieved?

Federal coordination mandate in Title XX, PHS Act

It is not well known that the Title XX AFL legislation does include a broad coordination mandate. Under the heading "Coordination of Federal and State Programs", Section 2007 of the legislation reads that----

"the Secretary shall coordinate Federal policies and programs providing services relating to the prevention of adolescent sexual relations and initial and recurrent adolescent pregnancies and providing care services for pregnant adolescents. In achieving such coordination the Secretary shall.....

....(2) require grantees to report periodically to the Secretary concerning Federal, State and local policies and programs that interfere with the delivery of and coordination of pregnancy prevention programs and other programs of care for pregnant adolescents and adolescent parents.
....(3) review all programs administered by the DHHS which provide prevention services or care services to determine if the policies of such programs are consistent with the policies of this title, consult with other departments and agencies of the Federal government who administer programs that provide such services, and encourage such other departments and agencies to make recommendations, as appropriate for legislation to modify such programs in order to facilitate the use of all Government programs..."

Other provisions of this section relate to coordination activities of the grantees. These coordination provisions were included in the original 1978 legislation and have been little changed since. They are also included in the Kennedy and Leland bills. They have never been implemented. Coordination requires time and resources, and some accountability to overcome the inherent barriers. The AFL provisions do not allocate specific resources to these activities, nor do they spell out the need to report to the Congress on them.

However, these provisions in the current law, if amended to give them some financial resources and administrative "clout", would seem to provide the legislative mandate for federal coordination the Southern Regional Project is recommending in their report.

SUMMARY LISTING OF FEDERAL PROGRAMS THAT AFFECT TEEN PREGNANCY AND EARLY CHILDBEARING

(Sources: Select Committee, 1990; Moore, 1981 and 1983; Reingold and Assoc. 1986) *Note: This is a summary listing of federal programs that do, or potentially could, help prevent teenage pregnancy or provide assistance to pregnant teenagers and teen parents. However there is very little information available, for the most part, on how many teenagers are in fact reached by these programs.*

HEALTH

Medicaid
Medicaid, a federal/state matching program, is the primary source of federal financing of family planning services for low-income teens, and for prenatal and postnatal care, and pediatric care. Within this broad program, the Early Periodic Screening Diagnosis and Treatment program is growing in importance as a resource for teen parents. The various Medicaid Waiver programs help fund home-based services for teenage parents whose children have special health care needs.

Government Employees Health Benefits Programs
Dependent health care benefits are available to dependents, or dependents' survivors, of federal civilian and military employees through three programs.

---Federal Employees Health Benefits Program (FEHB)

---Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

---Civilian Health and Medical Program of the Department of Veteran's Affairs (CHAMPVA)

Maternal and Child Health Block Grants
The maternal and child health (MCH) Title V services block grant provides health services to mothers and children, particularly those with low income or limited access to health services. The purposes of the block grant include reducing infant mortality; reducing the incidence of preventable disease and handicapping conditions among children; and increasing the availability of prenatal, delivery, and post-partum care to low-income mothers. Title V funds may also be used for family planning services. In addition, Community Health Centers and Neighborhood health centers funded under different legislation provides a variety of health services to low-income mothers and children.

FAMILY PLANNING PROGRAMS
(In addition to Medicaid and Title V)

Title X
Title X, of the Public Health Services Act provides a variety of family planning services to teenagers, without parental notification or consent, (unless state law requires it) and regardless of ability to pay. The program targets low-income women but there are no eligibility requirements. About one-third of the clients served are teenagers.

Title XX Social Services Block Grants
Social services block grants are provided to states for activities determined appropriate social services by the state. Typical activities include child care, protective services for children and

adults, and home care services for the elderly and handicapped. Family planning is one of the services these grants may pay for. There are no federal eligibility requirements. The program is administered by OHDS/HHS.

ADOLESCENT FAMILY LIFE PROGRAM, TITLE XX of the Public Health Services Act. This is a demonstration grants program to provide comprehensives services to help teenagers delay sexual activity, and help pregnant teens and teen parents and their families. (See page 8 above for more detail.) It is the only federal program explicitly and exclusively targeted to this population. Administered by the Office of Population Affairs.

Alcohol, Drug Abuse and Mental Health Administration (ADAMHA)

ADAMHA Block Grant
Funds in this program are allocated to the states to provide alcohol, drug abuse, and mental health treatment services to target populations and for specific purposes. In FY '86 Congress designated a 5 percent set-aside within this block grant for women's alcohol and drug abuse services. The set-aside was raised to 10 percent in FY '89 and statutory language was added to place an emphasis on programs for pregnant women and women with dependent children. The grant is administered by the Office for Treatment Improvement.

Office of Treatment Improvement / ADAMHA
ADAMHA's new Office for Treatment Improvement was established to improve drug treatment services throughout the country. The office plans to provide grants and technical assistance to high-risk populations such as pregnant drug-abusing women, adolescents, and intravenous drug abusers. In October 1989 a conference focusing on adolescent treatment was held.

Office for Substance Abuse Prevention, ADAMHA
High Risk Youth Grants
The primary purpose of the Office of Substance Abuse Prevention (OSAP) is to prevent alcohol and drug abuse problems. The Office has several major initiatives for high-risk youth who are defined broadly in the legislation as individuals under 21 who have started to use alcohol and other drugs, who are the children of substance abusers, victims of sexual/ physical abuse, are pregnant, high school drop outs, economically disadvantaged delinquent, have attempted suicide or experienced other mental health problems, etc. In addition, in collaboration with the Bureau of Maternal and Child Health, OSAP funds model projects for substance abusing pregnant and postpartum women and their infants.

Center for Disease Control
The Adolescent and School Health Division of the CDC has begun a new initiative to increase AIDS education in schools. The program funds every state education department in the United States, sixteen local school districts that have high incidence of HIV infection (such as Chicago and New York), and 21 national organizations such as the Parent Teachers Association (PTA) and The National Coalition of Hispanic Health and Human Services Organizations (COSSMHOS). The purpose of the grants are to increase the number of schools providing AIDS education and courses that integrate AIDS prevention with teen pregnancy prevention, drug abuse prevention, and drop out prevention. Grants also aim to increase the number of teenagers with HIV prevention knowledge. The program is administered by the Center for Disease Control, a division of HHS in Atlanta, Georgia.

National Institute for Child Health and Development, National Institutes of Health
This office has been the major source of funding for research into the causes and consequences of early childbearing.

INCOME SUPPORT

AFDC Program

The Aid to Families with Dependent Children (AFDC) program provides cash payments to needy children (and their caretakers) who lack support because at least one parent is absent from the home. It is the primary source of public income support for teen mothers and their children. (Other programs include the Supplemental Security Income Program for disabled children and adults.) Some states currently provide the benefit if one parent is unemployed and in October 1990, all states will be required to provide AFDC for 6 out of 12 months if one parent in a two-parent family is unemployed. A family's benefit is determined primarily by the state. AFDC eligibility entitles recipients to Medicaid coverage and food stamps. Generally, AFDC eligibility ends upon a child's 18th birthday. The AFDC program is administered by the Office of Family Assistance, FSA, DHHS.

As a condition of eligibility, AFDC mothers must assign their child support rights to the state and cooperate with welfare offices in establishing paternity of a child born outside of marriage and in obtaining child support payments.

The Family Support Act of 1988 imposed new requirements on teen mothers. Beginning in October 1990, Federal law requires states, to the extent resources permit, to require able-bodied recipients with no child under age 3 to participate in the State's education, training, and work program (JOBS). Teen parents under age 20 who have not completed their high school education are required to enroll in continued education and then in the Jobs Opportunities and Basic Skills program, no matter how young their child is.

Child Support Enforcement Program

Title IV of the Social Security Act establishes a program of child support enforcement and paternity establishment. It provides these services both to AFDC parents and to non-AFDC parents. This program has been greatly strengthened by the provisions of the Family Support Act 1988.

EDUCATION

Title IX of 1972 Education Amendments prohibits expulsion or exclusion of pregnant students from school.

Vocational Education: Carl D. Perkins Program

Grants are provided to states to provide a variety of vocational education services to economically disadvantaged youth and adults, and handicapped persons. The programs specifically targets single parents.

Women's Educational Equity Act

Under the Act, grants and contracts are made by the U.S. Secretary of Education to organizations or individuals to develop materials, initiate model training programs, conduct research, provide guidance and counseling activities, and provide other educational activities and programs that promote educational equity for women and girls in the United States.

In addition, a number of education programs may help teenagers at risk of teen pregnancy, teen parents, and their children, including the following.

---Programs within the Elementary and Secondary Education division which provide funds to school districts to improve the quality of education for disadvantaged children (e.g. Chapter I)

---Drug-Free Schools and Communities Program

---Migrant High School Equivalency Program

---Indian Education

---Education Programs for Children with Handicaps (EHA)

---PL 99-457 Part H, The Handicapped Infants and Toddlers Program

EMPLOYMENT, TRAINING AND SOCIAL SERVICES

Job Training Partnership Act

Funds are provided to states and localities to provide employment-related training to economically disadvantaged adults and youth. Eligible activities include remedial education, on-the-job training in the public and private sectors, a limited amount of subsidized employment for youth, work experience, and a limited amount of supportive services. The program is administered by the Employment and Training Administration, the U.S. Department of Labor (DOL). Of funds received by local areas, 40 percent must be spent on services to eligible youth, aged 16-21.

CHILD CARE

(Four programs account for more than 90 percent of all federal spending for child care: Head Start, the Child Care Food Program, employer subsidies, and the Dependent Care Tax Credit. There are 17 other Federal programs that can provide child care such as the Community Service Block Grant and the Job Training Partnership Act.)

Head Start Bureau, ACYF

Head Start is a comprehensive child development program which serves approximately 450,000 low-income preschool children. Head Start staff recognize that substance abuse is a growing problem among the families they serve, and estimate that at least 20 percent of children in the program have a parent or guardian with substance abuse problems. Head Start has proposed new initiatives to address the issue, including additional staff training and the development of curricula aimed at preventing substance abuse. Several programs serving HIV+ children are being funded as Head Start Innovative Projects.

Child Care Food Program

The child care food program was designed to assist states in providing nutritious meals to children in day care centers, family and group day care homes, and head start centers. Program sponsorship is limited to public and private nonprofit child care centers and family and group day care homes. For-profit sponsors may receive assistance under the social services block grant (Title XX of the Social Security Act) for at least 25 percent of the children they serve. The program is administered by the Food and Nutrition Service in the Department of Agriculture.

Comprehensive Child Development Centers, ACYF

A new program in its first year of operation, these centers are intended to provide intensive, comprehensive, integrated, and continuous supportive services for infants, toddlers, and preschoolers from low-income families to enhance their intellectual, social, emotional and physical development, and provide support to their parents and other family members.

Tax Benefit Child Care Programs

In general, teen parents are unlikely to avail themselves of tax benefits to help fund their child care expenses but the potential is there for those teenage parents who do become employed especially if the credits become refundable. These tax provisions include:

---Dependent Care Tax Credit

---Earned Income Tax Credit

Runaway and Homeless Youth Program and the Drug Abuse Prevention Program for Runaway Youth

The runaway and homeless youth program funds local facilities providing temporary residential care and counseling, a national toll free hotline for runaway and homeless youth and their families, transitional living projects, and drug abuse prevention services. The program is designed to meet the needs of these youth outside the law enforcement structure and the juvenile justice system. The law does not specify age or other eligibility criteria for the program; the regulations define "youth" as a person under the age of 18. The runaway and homeless youth program is administered by the Administration for Children, Youth, and Families.

Child Welfare Services

The child welfare services program, comprising several titles of the Social Security Act authorizes Federal matching funds for the provision of child welfare services to children and their families without Federal income eligibility requirements. Services can include those intended to protect the welfare of children; help prevent or solve problems that may result in the neglect, abuse, exploitation, or delinquency of children; help prevent the separation of children from their families and help return children who have been removed to their families; and provide for the care of children who cannot be returned home. The majority of the child welfare services funds (Federal and state combined) are spent on foster care services. Other services provided include counseling and rehabilitation; adoption subsidies and services; and child protection services.

---Title IV-E Foster Care Program is a permanently authorized, open-ended, entitlement program which provides payments to states to reimburse a substantial portion of the maintenance costs of licensed or approved out-of-home care provided to children eligible to receive AFDC.

---Title IV-B Child Welfare Services Program authorizes and funds three activities relating to child welfare services; direct services, child welfare research and demonstration projects; and child welfare training.

---Title IV-E Independent Living Program funds services to help facilitate the transition of children in foster care to independent living.

---Title IV-E Adoption Assistance Program is an open-ended entitlement to the states requiring them to provide subsidies to parents for "special needs" adoption.

Juvenile Justice and Delinquency

The Juvenile Justice and Delinquency Prevention Act is an attempt by the Federal Government to assist the states, local governments, and private not-for-profit agencies to develop programs aimed at the prevention and treatment of delinquency among juveniles. The three programs authorized by the Act: juvenile justice and delinquency prevention, missing children's assistance, and prevention and treatment programs relating to juvenile gangs and drug abuse and drug trafficking. The program is a state's formula grants program.

Abandoned Infants Assistance Demonstration Grants Program

In 1988 Congress passed legislation to authorize the use of up to $10 million to meet the needs of boarder babies, including efforts to prevent abandonment, support services for abandoned infants, and capacity building efforts to help hospitals, child welfare agencies, and others better serve these children. The program was not funded in FY '89 but has received $9 million in FY '90. It is administered by the Children's Bureau.

The Temporary Care for Children with Disabilities and Crisis Nurseries Program
Authorized under the Temporary Child Care for Handicapped Children and Crisis Nurseries Act, this demonstration grants program, administered by the Children's Bureau (ACYF), was enacted in 1986 to serve abused and neglected infants and young children, some of whom are from drug involved families. Thirty-four projects are being funded (16 in FY '88 and 18 in FY '89) for a total of $5 million. Four of the FY '88 projects focus specifically on drug addicted babies, and three serve HIV+ children.

HOUSING PROGRAMS

Low-income Public Housing
Low-income public housing projects are designed to provide low-income rent, standard-quality housing, primarily to families with children. To be eligible for public housing, households must have incomes under 80 percent of the median income of the area, adjusted for family size. Since 1983, 75 to 95 percent of all units must be rented to households with income below 50 percent of the local median, adjusted for family size.

The program is run through the Office of Public Housing of the Department of Housing and Urban Development (HUD) and local public housing agencies.

Leased Housing Assistance (Section 8 Program)
The program was established to assist low-income households in occupying privately-owned, modest-quality and modestly priced housing. Preference is given to families. The Federal government makes a payment to a landlord on behalf of the tenant household, for the difference between the tenant's rent payment and a contract rent set by the landlord in agreement with the U.S. Department of Housing and Urban Development (HUD) or the administering local public housing agencies, which cannot exceed fair market rents set by HUD for the type of structure and size of unit.

FOOD AND NUTRITION PROGRAMS

Food Stamps
The food stamp program provides a monthly supplement, in the form of food stamps, to the food purchasing power of low-income individuals and families. Food stamp benefits received are usable to purchase food for home consumption and, in certain cases, prepared meals or food-related items such as seeds and plants for growing food at home. Eligibility generally depends on a household's monthly cash income and liquid assets: however, most adult household members also must fulfill any work-related requirements imposed by administering State welfare agencies. The program aims at assisting households where all members receive aid to families with dependent children (AFDC) or supplemental security income (SSI) benefits are automatically eligible for food stamps. The program is administered by the Food and Nutrition Service, Department of Agriculture.

Special Milk Program
The program provides Federal funds for milk served to children in public and private nonprofit schools and child care institutions provided that these schools do not participate in other Federal child nutrition programs.

Special Supplemental Food Program for Women, Infants, and Children (WIC)
The special supplemental food program for women, infants, and children (WIC) provides nutritious supplemental foods to pregnant and postpartum women, infants, and children through

age 4, who are determined to be at nutritional risk because of inadequate nutrition and inadequate income. Beneficiaries receive supplemental food, as specified by the USDA regulations. This is provided either in the form of actual food items, or vouchers valid for purchases of specific food items in retail stores. Among the items that may be included in the WIC package are milk, cheese, eggs, infant formula, cereals, and fruit or vegetable juices. USDA regulations require tailored food packages that provide specified types and amounts of food appropriate for six categories of participants; infants from birth through 3 months, infants from 4-12 months, women and children with special dietary needs, children 1-4 years of age, pregnant nursing mothers, and postpartum nonnursing mothers.

Income standards for participation are generally determined by the state and local agencies; however, by law such standards may not exceed the income eligibility level set for reduced-price school lunches (i.e. 185 percent of agencies may not set income standards that are less than 100 percent of the Federal poverty guidelines). WIC is run through the Food and Nutrition Service of the USDA.

Commodity Supplemental Food Program (CSFP)

The commodity supplemental food program (CSFP) provides federally purchased commodities to states which in turn distribute these commodities to low-income pregnant, postpartum, and nursing mothers, and infants and children through age 5 who are vulnerable to malnutrition. Food provided under the program consist of an array of the USDA commodities which include surplus cheese, nonfat dry milk, canned fruits and vegetables and juices, canned beef, peanut butter, and cereal. To participate in the CSFP, participants must have incomes which would qualify them for other Federal, state, or local low-income programs. In addition, participants in some states must be determined to be at nutritional risk. No person may participate in both the CSFP and women, infants, and children (WIC) at the same time.

SELECTED REFERENCES

Alan Guttmacher Institute. *Readings on Teenage Pregnancy*. Articles from Family Planning Perspectives, 1985-1989. New York, NY: Alan Guttmacher Institute, 1990.

Biesmesderfer, S.C., Maggard, H.F., Bustos, P.D. *Teenage Pregnancy Legislation in the States: 1988*. Denver, Colorado: National Conference of State Legislatures, June 1989.

Burt, M. and Levy, F. "The Estimates of Public Costs for Teenage Childbearing: A Review of Recent Studies and Estimates of 1985 Public Costs, " in *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing*. Volume II Working Papers and Statistical Appendixes. Edited by Sandra Hofferth and Cheryl Hayes. Washington, DC: National Academy Press, 1987.

Coates, D.L. and Maxwell, J.P. *Lessons Learned from the Better Babies Project*. Notes from the Field. April 1990. Available from Community Services Department, March of Dimes Foundation, 1275 Mamaroneck Ave. White Plains, NY 10605.

Family Support Administration. *On Teen Pregnancy Prevention: A Report from the Secretary's Panel*. January 1989. U.S. Dept. of Health and Human Services. Available from SHARE Resource Center on Teen Pregnancy Prevention. P.O. Box 2309, Rockville, MD 20852.

Hayes, C. ed. *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing*. Volume I Final Report of the Panel on Adolescent Pregnancy and Childbearing, Committee on Child Development Research and Public Policy, National Research Council. Washington, DC: National Academy Press, 1987.

Henshaw, S.K., Kenney, A.M., Somberg, D., Van Vort, J. *Teenage Pregnancy in the United States: The Scope of the Problem and State Responses*. New York, NY: The Alan Guttmacher Institute, 1989.

Henshaw, S.K., Van Vort, J. "Teenage Abortion, Birth and Pregnancy Statistics: An Update" in *Family Planning Perspectives*. Vol. 21, No. 3, March/April 1989. Included in the Alan Guttmacher Institute *Readings on Teenage Pregnancy 1990*

Kenney, A.M. and Somberg, D., *State Teenage Pregnancy Initiatives in the 1980s: An Assessment*. in Henshaw *et. al.*, 1989. op. cit.

Kenney, A.M., Guardado, S. and Brown, L. "Sex Education and AIDS Education in the Schools: What States and Large School Districts Are Doing." *Family Planning Perspectives*. Vol 21, No 2. March/ April 1989. Included in the Alan Guttmacher Institute *Readings on Teenage Pregnancy 1990*.

Koshel, J. J. *An Overview of State Policies Affecting Adolescent Pregnancy and Parenting*. Center for Policy Research, Human Resources Policy Studies. Washington, DC: National Governors' Association, 1990.

Moore, K.A. "Government Policies Related to Teenage Family Formation and Functioning: An Inventory" in *Teenage Pregnancy in a Family Context: Implications for Policy*. edited by T. Ooms. Philadelphia: Temple University Press, 1981.

Moore, K.A., Burt, M.R. *Private Crisis, Public Cost: Policy Perspectives on Teenage Childbearing*. Washington, DC: Urban Institute, 1982.

Moore, K.A. *Adolescent Parents: Federal Programs and Policies*. Summer 1983. Report prepared for the C.S. Mott Foundation. Available from the author, Child Trends Inc. 2100 M St. N.W., Suite 610, Washington, DC 20037

Moore, K.A. *Facts At A Glance 1989*. Annual updated facts sheets related to teen pregnancy and childbearing in the 50 states. Available from Child Trends Inc. 2100 M St. N.W., Suite 610, Washington, DC 20037.

National Commission to Prevent Infant Mortality. *Death Before Life: The Tragedy of Infant Mortality*. A report and recommendations of the Commission. Washington, DC: National Commission to Prevent Infant Mortality, 1988.

National Commission. *Adolescent Pregnancy: An Issue Brief*, 1988. Available from the National Commission to Prevent Infant Mortality, 330 C St. S.W., Room 2006, Washington, DC 20201.

National Commission. *Troubling Trends: The Health of America's Next Generation*. Report of the National Commission to Prevent Infant Mortality. February 1990. Available from the Commission, 330 C St. S.W., Room 2006, Washington, DC 20201.

North Carolina Coalition (NCCAP). *The Challenge and the Choices: Teen Pregnancy in North Carolina*. Report of the Action Agenda. 1989. Available from the North Carolina Coalition of Adolescent Pregnancy, 1300 Baxter St., Suite 171, Charlotte, NC 28204.

Ooms, T. ed. *Teenage Pregnancy in a Family Context: Implications for Policy*. Philadelphia: Temple University Press, 1981

Parents Too Soon (PTS) *Progress Report*. A program of the State of Illinois. 1988 Available from Parents Too Soon, 535 W. Jefferson, Springfield, IL 62761.

Reingold, J.R.& Associates. *Current Federal Policies and Programs for Youth. June 1987*. A report of Youth and America's Future, the William T. Grant Foundation Commission on Work, Family and Citizenship. Available from the Commission, Suite 301, 1001 Connecticut Avenue N.W., Washington, DC 20036.

Schorr, L. chair. *Better Health for Our Children: A National Strategy*. The Report of the Select Panel for the Promotion of Child Health to the U.S. Congress and the Secretary of DHHS. DHHS Pub. No. 79-55071 Washington, DC: U.S. Government Printing Office, 1981

Select Committee on Children, Youth and Families. *Teen Pregnancy: What is Being Done? A State-by-State Look*. A Committee report together with additional minority views. U.S. House of Representatives, 99th Congress. Washington, DC: U.S. Government Printing Office, 1986.

Select Committee on Children, Youth, and Families. *Federal Programs Affecting Children and Their Families, 1990*. A report together with additional minority views. U. S. House of Representatives, 101st Congress.Washington, DC: U.S. Government Printing Office, 1990.

Southern Regional Project. *Adolescent Pregnancy in the South: Breaking the Cycle*. A Report of the Southern Regional Project on Infant Mortality. May, 1989. Available from the Southern Regional Project, 444 N. Capitol St. N. W., Suite 240, Washington, DC 20001.

Southern Regional Project. *Adolescents in the South: A Mandate for Leadership*. July 1990. Available from the Southern Regional Project, 444 North Capitol St. N. W., Suite 240, Washington, DC 20001.

TEC Networks, *Theme Issue: Lessons Learned/Recommendations*. Newsletter of the Too-Early-Childbearing Networks of Programs Funded by the Charles Stewart Mott Foundation.No. 25, June 1990.

Weatherley, R.A., Perlman, SD. B., Levine, M.H., Klerman, L.V. "Comprehensive Programs for Pregnant Teenagers and Teenage Parents: How Successful Have They Been?" in *Family Planning Perspectives*. Vol. 18, No. 2, March/April 1986. Included in the Alan Guttmacher Institute, *Readings in Teenage Pregnancy*.

Table 11
Summary of Major State Responses to Adolescent Pregnancy and Parenting

State	Coordinated Programs and Policies	Health Care Programs			Educational Programs				Employment Programs for At-Risk Youth
		Family Planning Services[1]	School-Based Clinics[2]	Medicaid Above 133%[3]	Preschool[4]	Middle Grades[5]	School Dropout[6]	Sex Education[7]	
Alabama		■				■			
Alaska						■			
Arizona									
Arkansas			■					■	
California	■	■		■	■	■	■		■
Colorado	■		■						■
Connecticut	■	■	■	■		■			■
Delaware						■		■	
Florida				■	■	■	■		■
Georgia		■	■			■	■	■	
Hawaii				■			■	■	
Idaho									
Illinois	■	■	■		■	■	■		
Indiana							■		
Iowa				■				■	
Kansas				■				■	
Kentucky		■			■			■	
Louisiana		■			■	■	■		
Maine	■	■	■	■					■
Maryland	■	■	■	■	■	■		■	■
Massachusetts	■			■	■	■			■
Michigan		■	■	■	■	■	■		■
Minnesota		■		■	■		■		■
Mississippi		■		■		■	■		
Missouri					■	■	■		
Montana									
Nebraska									
Nevada								■	
New Hampshire							■		
New Jersey	■	■	■		■		■	■	■
New Mexico	■							■	
New York	■	■	■	■	■		■		■
North Carolina		■	■	■			■		
North Dakota							■		

From: Koshel, J. An Overview of State Policies Affecting Adolescent Pregnancy and Parenting. Center for Policy Research, Human Resources Policy Studies. Washington, D.C.: National Governors' Association, 1990

Table 11
Summary of Major State Responses to Adolescent Pregnancy and Parenting (continued)

State	Coordinated Programs and Policies	Health Care Programs			Educational Programs				Employment Programs for At-Risk Youth
		Family Planning Services[1]	School-Based Clinics[2]	Medicaid Above 133%[3]	Preschool[4]	Middle Grades[5]	School Dropout[6]	Sex Education[7]	
Ohio	■	■			■		■		■
Oklahoma		■							
Oregon	■		■		■	■	■		
Pennsylvania	■	■			■	■	■		
Rhode Island	■		■	■		■	■	■	
South Carolina		■		■	■	■		■	
South Dakota						■			
Tennessee		■				■	■		
Texas		■			■		■		
Utah							■	■	
Vermont				■		■		■	
Virginia	■	■				■	■	■	■
Washington	■	■		■	■	■	■		■
West Virginia		■		■		■		■	
Wisconsin	■	■			■	■	■		■
Wyoming						■			
Total	17	25	13	19	19	26	26	17	15

NOTES:
1. Block grants and other state funds for non-Medicaid family planning services total more than $1 million per year.
2. State funds school-based clinics.
3. Medicaid coverage of pregnant women and children above 133 percent of the federal poverty level.
4. State funding for preschool programs totals more than $1 million per year.
5. State funds middle grades model programs and dissemination.
6. State has statewide dropout program(s) for secondary school-aged youth.
7. Sex education is required by the state.

BEST COPY AVAILABLE

From: Koshel, J. An Overview of State Policies Affecting Adolescent Pregnancy and Parenting. Center for Policy Research, Human Resources Policy Studies. Washington D.C.: National Governors' Association, 1990.